

IN THE WAITANGI TRIBUNAL

Wai 2575

Wai 2894

IN THE MATTER OF

the Treaty of Waitangi Act 1975

AND

IN THE MATTER OF

the Health Services and Outcomes
Kaupapa Inquiry (Wai 2575)

AND

IN THE MATTER OF

a claim by **Malcolm J Kingi** on behalf
of **Ngai Tāhū o Mohaka Waikare**

FIRST AMENDED STATEMENT OF CLAIM

Date: 12 December 2019

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MAY IT PLEASE THE TRIBUNAL

THE CLAIM

1. This First Amended Statement of Claim is filed on behalf of Malcolm J Kingi on behalf of Ngai Tāhū O Mohaka Waikare (“the Claimants”).
2. This First Amended Statement of Claim is specific to the disability phase of Stage Two of the Health Services and Outcomes Kaupapa Inquiry. It is supplementary to and should be read in conjunction with other pleadings filed in this inquiry on behalf of the Claimants.
3. The Claimants say that their claim falls within one or more of the matters referred to in section 6(1) of the Treaty of Waitangi Act 1975 namely:
 - a. that they are Maori, and
 - b. they have been and continue to be or are likely to be prejudicially affected by the various Acts and Crown policies, practices, acts and omissions adopted by, or on behalf of the Crown or its agents.
4. The Claimants reserve the right to amend this First Amended Statement of Claim.

TE TIRITI Ō WAITANGI PRINCIPLES

Partnership

5. The constitutional status of Māori as first peoples¹ gives rise to a presumption of equal status between treaty partners. The rights (of governance and autonomy) each treaty partner accords to the other are not absolute but subject to each partner’s needs.² One party should not benefit by constraining the other party from benefiting.

¹ Waitangi Tribunal, *Report of the Waitangi Tribunal on the Motunui-Waitara Claim* (Wai 6, 1983), at 52; Waitangi Tribunal, *Report of the Waitangi Tribunal on the Orakei Claim* (Wai 9, 1987), at 183; Waitangi Tribunal, *The Taranaki Report: Kaupapa Tuatahi* (Wai 143, 1996), at 18-21; Waitangi Tribunal, *Muriwhenua Land Report* (Wai 45, 1997), at 114; Waitangi Tribunal, *The Wananga Capital Establishment Report* (Wai 718, 1999), at 44.

² Waitangi Tribunal, *Te Whānau o Waipareira Report* (Wai 414, 1998), at 8.

6. Māori and the Crown should act honourably, reasonably and in good faith towards one another because of their special relationship created by Te Tiriti ō Waitangi (“Te Tiriti”).³ Moreover, for the partnership to work, the Crown must deal openly and honestly with Māori.⁴
7. In attempting to reduce health disparity the Crown⁵ has an obligation to do so in good faith and partnership. It cannot simply present Maori with its own solutions, however well-intentioned they might be; at minimum it must consult with Maori, and ideally it will either form a partnership with, or deliver funding and autonomy to Maori organisations.
8. Reciprocity is a fundamental cornerstone of partnership. The exchanges required within a functioning partnership should involve benefits that are mutual, with advantages flowing in both directions.⁶
9. The Crown has a duty to consult with Māori. Whānau, hapū and iwi should be consulted with respect to local issues.⁷ A failure to consult is likely to result in an affront to Māori.⁸

Active Protection

10. Through Te Tiriti, the Crown assured Māori that their existing rights would be actively protected with the utmost good faith⁹ and to the fullest practicable extent.¹⁰ The principle of active protection applies to non-kin-based Māori communities¹¹ and to all Māori interests including Māori health outcomes.¹²

³ *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513 (“Broadcasting Assets”); *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 (“Lands”).

⁴ Waitangi Tribunal, *He Whiritaunoka: The Whanganui Land Report* (Wai 903, 2015), at 156.

⁵ Waitangi Tribunal, *Te Urewera Report, Part IV*, 2015, Wai 894, at 659.

⁶ Waitangi Tribunal, *He Whiritaunoka: The Whanganui Land Report* (Wai 903, 2015), at 156.

⁷ Waitangi Tribunal, *Mangonui Sewerage Report* (Wai 17, 1988), at 187.

⁸ Waitangi Tribunal, *Manukau Report, Vol 2* (Wai 8, 1989), at 87.

⁹ *New Zealand Maori Council v Attorney General* [1987] 1 NZLR at 715.

¹⁰ Waitangi Tribunal, *Turanga Tangata Turanga Whenua, Vol 1* (Wai 814, 2004), at 120.

¹¹ Waitangi Tribunal, *Te Whānau o Waipareira Report* (Wai 414, 1998).

¹² Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at 62.

11. These interests include the right for Māori to retain rangatiratanga over their resources and taonga, which includes the management of such resources and other taonga according to Māori cultural preferences.¹³
12. The concept of taonga includes all valued resources and intangible cultural assets which are highly valued by Māori.¹⁴ Traditional rongoā is a taonga and the Crown has a duty to protect it.¹⁵
13. Te Tiriti placed an enduring obligation on the Crown to protect Māori from the adverse transitional effects of settlement.¹⁶ This obligation arises over and above considerations of equity. It calls for additional resources and effort to be deployed in favour of Māori whenever general programmes afford them insufficient protection.¹⁷
14. The scope of the active protection against ill health includes medical responses to the effects of ill health and remedial action against its causes.¹⁸ It includes remedial action against indirect causes such as environmental, social, economic, cultural, and institutional factors.¹⁹
15. The obligation to actively protect Māori interests is heightened in the knowledge of past historical wrongs done by the Crown and any prejudice that has affected subsequent generations.²⁰

Equal Treatment

16. Under ko te tuatoru o Te Tiriti, Māori have the same rights and privileges as British subjects. In this respect, the Crown has a duty to provide equality of healthcare, services, treatment and outcomes to Māori and non-Māori.

¹³ Waitangi Tribunal, *The Radio Spectrum Management and Development Final Report* (Wai 776, 1999), at 51; Waitangi Tribunal, *Report of the Waitangi Tribunal on the Muriwhenua Fishing Claim* (Wai 22, 1988), at 183.

¹⁴ Waitangi Tribunal, *Report of the Waitangi Tribunal on the Orakei Claim, Vol 3* (Wai 9, 1996), at 147.

¹⁵ Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at 49.

¹⁶ Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at xxv.

¹⁷ Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at [53].

¹⁸ Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at [53].

¹⁹ Waitangi Tribunal, *Tu Mai Te Rangi Report on Disproportionate Reoffending Rates*, 2017, Wai 2540, at 35.

²⁰ Waitangi Tribunal, *Taranaki Māori, Dairy Industry Changes, and the Crown* (Wellington: Legislation Direct, 2001), at 34.

17. Te Tiriti's promise of royal protection requires that the Crown have due regard for the well-being of Māori as part of the community of citizens including removing adverse health disparities.²¹
18. Where adverse disparities in health status between Māori and non-Māori are persistent and marked, the Crown is obliged to take appropriate measures on the basis of need, so as to minimise them over the long run.
19. The removal of adverse health disparities by appropriate means including affirmative action for Māori as a population group.²²

Self Determination

20. Māori retain their right to and to exercise tino rangatiratanga. Māori autonomy is the ability of tribal communities to govern themselves, to determine their own internal political, economic, social rights and objectives, and to act collectively in accordance with those determinants.²³
21. At the signing of te Tiriti, Māori could reasonably expect to obtain or retain the resources necessary for them to develop and prosper in the new, shared, nation state.²⁴

Options

22. The principle of options assures Māori of the right to choose their own social and cultural path.²⁵
23. The Crown may not offer exclusively monocultural services but must respect the most important facets of tikanga Māori within the public health system and in the delivery of social services.²⁶

²¹ Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at xxv.

²² Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at xxv.

²³ Waitangi Tribunal, *Turanga Tangata Turanga Whenua, Vol 1* (Wai 814, 2004), at 113.

²⁴ Waitangi Tribunal, *Te Tau Ihu o te Waka a Maui: Preliminary Report on the Customary Rights in the Northern South Island* (Wai 785, 2008), at 5.

²⁵ Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at 65.

²⁶ Waitangi Tribunal, *Napier Hospital and Health Services Report* (Wai 692, 2001), at 65.

Right to Development

24. Māori have the right to develop as a people, culturally, socially, economically and politically.²⁷ The Crown has the responsibility to guarantee that Māori have the right to develop, since such development is essential to Māori well-being.²⁸
25. The Crown has a duty to actively consider assisting with development opportunities when they arise in respect of Crown-owned or Crown-regulated resources or industries.²⁹
26. A Māori iwi or hapū may have a right to participate in any development occurring within their rohe, in any development related to tāonga or in any development that would assist their cultural, social, or economic development by contributing to the redress of past breaches of te Tiriti.³⁰

Redress

27. The Crown's duty to remedy past breaches of Te Tiriti involves granting redress.³¹ Tribunal jurisprudence has emphasised an active restorative approach.³²

UNITED NATIONS DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLE

28. The principles of te Tiriti are reinforced by the Crown's affirmation of the United Nations Declaration on the Rights of Indigenous Peoples ("the Declaration"). The Crown has indicated a commitment to uphold the rights contained within it. Additionally, the Supreme Court has observed that the

²⁷ Waitangi Tribunal, *He Maunga Rongo: Report on the Central North Island Claims, Stage 1, Vol 3 (Part 4)* (Wai 1200, 2008), at 914.

²⁸ Waitangi Tribunal, *Report of the Waitangi Tribunal on Claims Concerning the Allocation of Radio Frequencies* (Wai 26, Wai 150, 1990), at 41-43; Waitangi Tribunal, *Radio Spectrum Management and Development Interim Report* (Wai 776, 1999), at 7.

²⁹ Waitangi Tribunal, *He Maunga Rongo: Report on the Central North Island Claims, Stage 1, Vol 3 (Part 4)* (Wai 1200, 2008), at 913.

³⁰ Waitangi Tribunal, *He Maunga Rongo: Report on the Central North Island Claims, Stage 1, Vol 3 (Part 4)* (Wai 1200, 2008), at 913-914.

³¹ *New Zealand Maori Council v Attorney General* [1987] 1 NZLR 641, at 666.

³² Waitangi Tribunal, *He Maunga Rongo: Report on the Central North Island Claims, Stage 1, Vol 4 (Part 5)* (Wai 1200, 2008), at 1248.

Declaration supports the view that the principles of te Tiriti should be construed broadly.³³

29. In the context of health, Māori rights under the Declaration include the right to:
- a. Self-determination – The right to freely determine their political status and freely pursue their economic, social and cultural development.
 - b. Participate in decision-making – The right to maintain and develop their own decision-making institutions.
 - c. Protection from cultural assimilation – The right not to be subjected to the destruction of their Kaupapa Māori values.
 - d. Traditional medicines – The right to maintain their health practices and to have access without discrimination to all social and health services.
30. The highest attainable standard of physical and mental health – The State parties shall take the necessary steps with a view to achieving progressively the full realisation of the right.

FIRST CAUSE OF ACTION: THE CROWN FAILURE TO PROVIDE ADEQUATE DELIVERY OF DISABILITY SUPPORT SERVICES

Allegation

31. The Crown, in breach of Te Tiriti principles of active protection, good faith and partnership has failed to provide adequate disability services to the Claimants.

³³ *New Zealand Māori Council v Attorney-General* [2013] NZSC 6, at [92].

Particulars

32. Māori face considerable disparities in their lived experience of disability and access to disability services. This disparity is rooted in the Crown's failure to address the specific needs faced by the Claimants.
33. The Crown has knowledge of the inequitable lived experience of that disabled Māori suffer.
34. Crown data collected from the 2013 Disability Survey shows that Māori with lived experience of disability have a higher proportion of unmet need with regard to access to health professionals.³⁴
35. Crown data also shows that access to Disability Support Services is disproportionate to the needs of Māori with lived experience of disability.

Disability Support Services

36. Disability Support Services are prescribed in restricted circumstances.³⁵
37. The prescriptive nature of Crown purchasing guidelines for Disability Support Services does not align with the aim of social inclusion and the purpose of reducing health disparities for Māori outlined in the NZPHD Act.
38. Crown funding of Disability Support Services is limited to those people with a physical, intellectual and/or sensory impairment or disability that is:
 - a. likely to continue for a minimum of 6 months; and
 - b. reduces the ability to function independently, to the extent that ongoing support is required.

³⁴ Statistics New Zealand, 2014. 2013 *New Zealand Disability Survey*. Statistics New Zealand (Statistics New Zealand).

³⁵ Ministry of Health, About Disability Support Services < <https://www.health.govt.nz/our-work/disability-services/about-disability-support-services> > Accessed 24 April 2019.

39. This definition of disability used by the Ministry of Health to guide funding decisions focuses on physical functionality.
40. In order to receive, Disability Support Services, individuals are required to undergo a Needs Assessment conducted by Needs Assessment and Service Coordination Services (“NASC”).
41. Medical practitioners conduct these needs assessments and determine whether the individual will receive Crown support.
42. The prescriptive nature of Disability Support Service funding does not operate in the best interest of Māori.
43. Many Māori are left without access to much-needed disability support on the basis that they fail a functionality test.
44. The Crown failed to ensure equitable outcomes to the Claimants

Barriers to Access Disability Support Services

45. Māori with lived experience of disability have higher proportions of unmet need, despite having higher prevalence of disability.³⁶
46. Organisational barriers include the distance to travel for care, the availability of appointments at suitable times, waiting times, the (lack of) choice of provider, inflexibility of healthcare systems, and poor service-related experiences.³⁷
47. Cost barriers include direct costs (consultation costs, prescription charges), and indirect costs (loss of wages and travel and/or childcare expenses).³⁸

³⁶ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 30.

³⁷ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 30; Peter Jansen, Kira Bacal, and Sue Crengle, *He Ritenga Whakaaro: Māori Experiences of Health Services*. (Auckland: Mauri Ora Associates, 2008). [http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/2A6CAF401ABBEFB9CC2575F4000B6D0C/\\$file/He-Ritenga-Whakaaro.pdf](http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/2A6CAF401ABBEFB9CC2575F4000B6D0C/$file/He-Ritenga-Whakaaro.pdf), at 9.

³⁸ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 30; Peter Jansen, Kira Bacal, and Sue Crengle, *He Ritenga Whakaaro: Māori Experiences of Health Services*. (Auckland: Mauri Ora Associates, 2008).

Lack of services for visually impaired Māori

48. A stocktake and needs analysis of low vision services is required:³⁹

Based on the number of and location of low vision clinics and private optometrists providing low vision consultations identified in the stocktake, when compared to the prevalence of people who currently and in the future will experience low vision, there is a significant unmet need and services are inadequate...People in need of low vision services who identify as Māori...and/or who live in provincial and rural areas are not receiving adequate services currently. Low vision services in New Zealand are therefore inequitable and inadequate to meet the needs of people with low vision’.

49. For urban kāpo Māori who live where services are supposed to be available, services are not easily or readily accessible.⁴⁰

Financial Support for Carers of Māori With Lived Experience of Disability

50. Only recently have family members who provide care to those with disabilities been eligible for Crown funding.⁴¹
51. Even now that it is available, uptake is limited due to the restrictive criteria which is determined by MOH and DHBs.⁴²
52. Accessing this care is currently done through the Needs Assessment and Service Co-ordination Services. As at April 2015, only an estimated 191 disabled people were accessing this family funded care.⁴³
53. However recent Crown efforts that have gone into amending Part 4A of the New Zealand Public Health and Disability Act 2000, which provides for family

[http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/2A6CAF401ABBEFB9CC2575F4000B6D0C/\\$file/He-Ritenga-Whakaaro.pdf](http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/2A6CAF401ABBEFB9CC2575F4000B6D0C/$file/He-Ritenga-Whakaaro.pdf), at 9.

³⁹ Litmus Limited, *Stocktake and Needs Analysis of Low Vision Services in New Zealand*. (Wellington: Litmus Limited, 2015). <https://www.health.govt.nz/publication/stocktake-and-needs-analysis-low-vision-services-new-zealand>, at 6.

⁴⁰ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 33.

⁴¹ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 170.

⁴² T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 173.

⁴³ Artemis Research, *Evaluation of Funded Family Care*, (Wellington: Ministry of Health, 2015), accessed at <https://www.health.govt.nz/publication/evaluation-funded-family-care>, at iv.

funded care, have not sufficiently engaged with Māori with lived experiences of disability and their whānau.

SECOND CAUSE OF ACTION: THE FAILURE OF CROWN AGENTS TO PROVIDE ADEQUATE INCOME SUPPORT FOR MAORI WITH LIVED EXPERIENCE OF DISABILITIES

Allegation

54. The Crown, in breach of Te Tiriti principles of active protection, good faith and partnership has failed to provide adequate income support to Maori who have lived experience of disability

Particulars

55. The Crown's provision of income support plays an important role in the well-being and lived experience of Māori who are unable to work as a result of long-term impairment and disability.
56. The connection between disability and socio-economic disadvantage is well documented.
57. Disability increases the likelihood of socio-economic disadvantage and socio-economic disadvantage increases the likelihood of an injury developing into a long-term impairment.⁴⁴
58. The Crown provides income protection for working aged individuals living with an impairment in the following forms:
- a. Sickness Benefit;
 - b. Invalid's Benefit; or
 - c. Accident Compensation Corporation ("ACC").

⁴⁴ H Kaiwai and T Allport, *Maori with Disabilities (Part Two)* dated 28 June 2019, Wai 2575, #B23, at 83.

59. The Ministry of Social Development plays a key role in the broader disability framework through the provision of income protection to Māori living with disability.
60. A large proportion of disabled Māori are required to engage with government agencies in order to seek disability support and financial assistance.

Socio-economic status and disability

61. Disability has an adverse impact on the social, health and economic circumstances of Māori which directly impacts the overall health and well-being of whanau.
62. The Crown has knowledge that disability affects the likelihood of Māori being employed and remaining in full time employment.
63. The Crown conducted a Disability Survey in 2013 (the “Disability Survey”) and found that;
 - a. the unemployment rate is higher for disabled people;
 - b. 44% of disabled Māori were employed in comparison with 68% of non-disabled Maori; and ⁴⁵
 - a. living with disability increases the likelihood of having worse socio-economic status.
64. The Crown also has knowledge of the impact disability has on overall health and well-being for Māori.
65. The Disability Survey reflects that Māori were five times more likely to rate themselves as having poor health status than non-disabled Māori; ⁴⁶

⁴⁵ Statistics New Zealand. 2014. *2013 New Zealand Disability Survey*. Statistics New Zealand (Wellington).

⁴⁶ Statistics New Zealand. 2014. *2013 New Zealand Disability Survey*. Statistics New Zealand (Wellington).

Invalid's benefit

66. The Invalid's Benefit caters for individuals with long term and severe incapacitation.
67. In 1998, the Crown revised the qualifying criteria for individuals applying for the Invalid's Benefit from "75% incapacitated" to "permanently and severely restricted".
68. The Crown established a more restrictive qualifying criteria making it more challenging to receive government support.
69. Currently, to qualify for the Invalid's Benefit, the person must be "permanently and severely" restricted in his/ her capacity to work and have a condition that limits the capacity of the individual to engage in full time employment.
70. The payment of the Invalid's Benefit is also subject to the joint income of the individual living with a disability and their partner.
71. The Crown imposes a high threshold for qualification for the Invalid's Benefit leaving many Māori disadvantaged and unable to receive the requisite financial assistance.
72. The Crown's strict eligibility criteria does not operate in the best interests of Māori. The lack of adequate income support available to disabled Māori further perpetuates inequities in lived experience of disability.

Application to Claimants

73. The named Claimant applied for the Invalid's Benefit from Te Hiranga Tangata ("Work and Income") following a knee injury suffered by the Claimant in 1997.
74. Work and Income operates through the Ministry of Social Development and provides financial assistance in limited circumstances to individuals who are unable to work due to a health condition, injury or disability.

75. Work and Income apply restrictive eligibility criteria to applicants seeking income assistance for disability.
76. The joint income of the Claimant and his partner apparently exceeded the threshold. This has meant that the Claimants are not entitled to receive much needed income support.
77. The Crown failed to provide adequate financial support to the Claimants which caused increased financial pressure and strain on whānau resources and had a detrimental impact on the named Claimant's physical and mental wellbeing.
78. The named Claimant was required to continue working on an injured knee.
79. The named Claimant's knee injury worsened and is now a permanent disability.
80. On 29 October 2018, the named Claimant was issued a Disability Certificate by a registered medical practitioner for the purpose of receiving income support from the Crown.
81. The named Claimant is now deemed to have a permanent musculo-skeletal system disorder and has been forced to stop working.
82. The Claimants have suffered and continue to suffer as a result of the inadequate provision of income support.

THIRD CAUSE OF ACTION: THE CROWN FAILURE TO PROVIDE ADEQUATE DISABILITY SUPPORT SERVICES TO RURAL MĀORI

Allegation

83. The Crown, in breach of te Tiriti principles of active protection, good faith and partnership has failed to provide adequate rural health services to the Claimants, who are rural Māori.

Particulars

Rural Socio-economic Deprivation and Poor Health Outcomes

84. The rural Māori population has higher levels of socio-economic deprivation than non-Māori and as a result, they experience poorer health outcomes than non-Māori.⁴⁷
85. Socio-economic deprivation is regarded as a major determinant of health outcomes.⁴⁸ Factors such as income, employment status, housing and education all have both direct and indirect impacts on the negative health outcomes experienced by Māori.⁴⁹
86. In terms of the socio-economic indicators between rural Māori and urban non-Māori, the 2006 Census of Population and Dwellings undertaken by Statistics New Zealand recorded the following:
 - a. 39.1 percent of the rural Māori population achieved school completion (Level 2 Certificate or higher), 15+ years, compared to 56 percent of the Non-Māori urban population;⁵⁰
 - b. 27.4 percent of the rural Māori population have a total personal income less than \$10,000, 15+ years, compared to 19.4 percent of the non-Māori urban population;⁵¹
 - c. 59.9 percent of the rural Māori population are not living in their own home, 15+ years, compared to 35.4 percent of the non-Māori urban population;⁵²

⁴⁷ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 16.

⁴⁸ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 16.

⁴⁹ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁵⁰ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁵¹ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁵² Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

- d. 6.5 percent of the rural Māori population are living in a household without telecommunications access, all age groups, compared to 1 percent of the non-Māori urban population;⁵³
 - e. 5.1 percent of the rural Māori population are living in a household without motor vehicle access, all age groups, compared to 1.2 percent of the non-Māori urban population;⁵⁴ and
 - f. 19.4 percent of the rural Māori population are living in household crowding (1 or more bedrooms required), all age groups, compared to 3.3 percent of the non-Māori urban population.⁵⁵
87. For comparative purposes, we have also set out the socio-economic indicators between rural Māori and urban Māori. The 2006 Census of Population and Dwellings undertaken by Statistics New Zealand indicates the following:
- a. 39.1 percent of the rural Māori population achieved school completion (Level 2 Certificate or higher), 15+ years, compared to 45.8 percent of the Māori urban population;⁵⁶
 - b. 27.4 percent of the rural Māori population have a total personal income less than \$10,000, 15+ years, compared to 24.9 percent of the Māori urban population;⁵⁷
 - c. 59.9 percent of the rural Māori population are not living in their own home, 15+ years, compared to 72.7 percent of the Māori urban population;⁵⁸

⁵³ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁵⁴ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁵⁵ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 18.

⁵⁶ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁵⁷ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁵⁸ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

- d. 6.5 percent of the rural Māori population are living in a household without telecommunications access, all age groups, compared to 5.1 percent of the Māori urban population;⁵⁹
 - e. 5.1 percent of the rural Māori population are living in a household without motor vehicle access, all age groups, compared to 9.5 percent of the Māori urban population;⁶⁰ and
 - f. 19.4 percent of the rural Māori population are living in household crowding (1 or more bedrooms required) all age groups, compared to 23.7 percent of the Māori urban population.⁶¹
88. The underlying socio-economic deprivation experienced by rural Māori is the result of Crown acts and omissions including, but not limited to, the colonisation project, wholesale land alienation, the mis-delivery of education, economic ostracism and political marginalisation experienced by Māori.
89. The duty of the Crown to mitigate against the adverse health effects of the period following colonisation (the “transitional period”) has not been adhered to and as a result, rural Māori with lived experience of disabilities have suffered greater inequity and hardship.

Barriers to Access Rural Disability Support Services

90. Rural Māori are less likely to have a diversity of disability support services available to them:⁶²

‘...the majority of disability support services, particularly specialist services are concentrated in major urban centres like Hamilton, Tauranga, and Rotorua. People in major urban centres are also more likely than those in minor urban centres like Gisborne, Whakatane, and Opotiki and rural communities like Murupara, Tirau, Ruatoki, Whatawhata, and Waimana to have a diversity of disability support

⁵⁹ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁶⁰ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 17.

⁶¹ Bridget Robson, Shirley Simmonds, Nohoana Findlay and Gordon Purdie, *Mātātūhi Tuawhenua: Health of Rural Maori 2012* (Ministry of Health, Wellington, 2012), at 18.

⁶² Nikora et al., *Disabled Maori and Disability Support Options: A report prepared for the Ministry of Health*, at 14.

services available to them, particularly community based services focused on specific disabilities like stroke, blindness, deafness, epilepsy, and on specific types of service delivery [for example,] Kaupapa Maori. However, in rural areas, tasks like visiting a medical practitioner, having blood tests completed, or accessing day care facilities, or specialists are complicated by the need for and expense of transport.

Lack of Transport to Rural Health Clinics

91. Access to funding for transport for Māori with lived experience of disability is “...problematic, especially in the rural areas”.⁶³
92. Rural Māori, those with disabilities and older people, suffer from limited access to appropriate transport services, which means it is more difficult for them to access rural health and disability services.⁶⁴
93. Availability of free or subsidised transport to hospitals is sporadic, especially in rural areas. Most disabled Māori use their own vehicles and do not access public transport subsidies. There is no nationwide data on availability of transport enabling access to healthcare. The cost of transport is a key issue for Māori with a disability.⁶⁵
94. While subsidies and grants are available to Māori with disabilities to buy vehicles, there is no support for ongoing transport costs for whānau using the vehicle for the benefit of a disabled whānau member’.⁶⁶
95. Whānau carers for Māori with disabilities in rural areas face severe challenges:⁶⁷

⁶³ The Centre for Health, Activity, and Rehabilitation Research. *Hauā Mana Māori: Living Unique and Enriched Lives - a Report for the Health Research Council and the Ministry of Health*. (Dunedin: University of Otago, 2014). <https://www.otago.ac.nz/physio/otago066906.pdf>, at 77.

⁶⁴ National Health Committee, *Rural Health: Challenges of Distance Opportunities for Innovation* dated January 2010, at 23.

⁶⁵ Adelaide Collins and Greg Wilson, *Māori and Informal Caregiving: A Background Paper Prepared for the National Health Committee*. Ministry of Health (Wellington: 2008). [http://www.moh.govt.nz/notebook/nbbooks.nsf/0/933A5FFFCE411AFECC2579A5006B42E3/\\$file/maoriinformal-caregiving-apr08.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/933A5FFFCE411AFECC2579A5006B42E3/$file/maoriinformal-caregiving-apr08.pdf), at 34.

⁶⁶ Collins and Wilson, *Māori and Informal Caregiving: A Background Paper Prepared for the National Health Committee*, at 34.

⁶⁷ Andrea M Corbett, "The Experience of Whānau Caring for Members Disabled from the Effects of Stroke." (Unpublished Masters thesis). Massey University, 2003., at 108.

...42 kilometres from the main hospital and rehabilitation service where the main outpatient day clinic services were provided [meant that, although there] was a small limited functioning outpatient rehabilitation clinic service offering primarily physiotherapy available in their country town and a small service further south...unless one has their own motor vehicle that access is denied them. This raises not only the issue of transport but also the issue of the lack of domiciliary rehabilitation physical service and supervision in the whanau member's own home'.

Human Resourcing Pressures

96. The Crown has failed to adequately resource Māori healthcare professionals within rural areas, and as a result this has contributed to greater disparities between Māori and non-Māori when accessing treatment.⁶⁸
97. Māori healthcare professionals are not adequately incentivised and therefore there is a huge shortage of healthcare professionals who practise in rural areas.⁶⁹
98. As a result of those shortages, major stresses are placed on healthcare professionals to deliver rural health services given the large number of people that need to be serviced within a specified region.⁷⁰
99. Māori healthcare providers say they have too many reporting requirements and are audited too frequently.⁷¹ As a result, there is less time available for patient contact.⁷²
100. As a result of multiple contracts, many healthcare professionals spend an inordinate amount of resources on reporting and compliance costs.⁷³

⁶⁸ National Health Committee, *Rural Health: Challenges of Distance Opportunities for Innovation* dated January 2010, at 23.

⁶⁹ National Health Committee, *Rural Health: Challenges of Distance Opportunities for Innovation* dated January 2010, at 23.

⁷⁰ National Health Committee, *Rural Health: Challenges of Distance Opportunities for Innovation* dated January 2010, at 23.

⁷¹ National Health Committee, *Rural Health: Challenges of Distance Opportunities for Innovation* (Wellington, 2010), at 23.

⁷² David Moore, Tom Love, Nieves Ehrenberg, *Review of Health Services on the East Coast – Public Report* (Sapere Research Group, 2013), at 36.

⁷³ National Health Committee, *Rural Health: Challenges of Distance Opportunities for Innovation* dated January 2010, at 24.

101. Māori healthcare professionals are not adequately incentivised to practice in rural areas and this contributes to the shortage of health care professionals working in rural areas.⁷⁴

FOURTH CAUSE OF ACTION: THE CROWN FAILURE TO PROVIDE ADEQUATE OPPORTUNITIES FOR MĀORI COMMUNITY CONSULTATION

Allegation

102. The Crown, in breach of the te Tiriti principles of active protection, good faith and partnership, has implemented a flawed community consultation model that has impeded the Claimants participation in decision-making regarding disability support services.

Particulars

Duty to Consult

103. The Crown's duty to consult with the Claimants and to obtain their full, free and informed consent on matters that affect them is derived from the te Tiriti principle of partnership and its own health-related legislation and policy framework.
104. The NZPHD Act requires the Ministry and DHBs to consult about matters related to the provision of health and disability services.
105. The standards of consultation for the Ministry and DHBs are set out in the Local Government Act 2002⁷⁵ and the Ministry's Consultation Guidelines.⁷⁶
106. The Crown has international obligations under the United Nations Declaration on the Rights of Indigenous People, which requires that states 'in consultation and cooperation with indigenous peoples, shall take the

⁷⁴ National Health Committee, *Rural Health: Challenges of Distance Opportunities for Innovation* dated January 2010, at 24.

⁷⁵ Local Government Act 2002, sections 82 to 90.

⁷⁶ Ministry of Health, *Consultation Guidelines for the Ministry of Health and District Health Boards relating to the provision of health and disability services* dated August 2002.

appropriate measures, including legislative measures, to achieve the ends of this Declaration'.⁷⁷

107. Community consultation requires the Crown to seek the views of individuals and community groups before deciding on specific issues.⁷⁸
108. The Court of Appeal has defined 'consultation' as a process that is more than notification but something less than negotiation and agreement.⁷⁹

Consultation must be allowed sufficient time, and genuine effort must be made. It is to be a reality, not a charade. The concept is grasped most clearly by an approach in principle. To 'consult' is not merely to tell or present. Nor, at the other extreme, is it to agree. Consultation does not necessarily involve negotiation toward an agreement, although the latter, not uncommonly, can follow, as the tendency in consultation is to at least seek consensus ...

... Consulting involves the statement of a proposal not yet finally decided upon, listening to what others have to say, considering their responses and then deciding what will be done.

Implicit in the concept is a requirement that the party consulted will be (or will be made) adequately informed so as to be able to make intelligent and useful responses. It is also implicit that the party obliged to consult, while quite entitled to have a working plan already in mind, must keep an open mind and be ready to change and even start afresh. Beyond that there are no universal requirements as to form. Any manner of oral or written interchange that allows adequate expression and consideration of views will suffice. Nor is there any universal requirement as to duration. In some situations adequate consultation could take place in one telephone call. In other contexts it might take years of formal meetings.

⁷⁷ United Nations Declaration on the Rights of Indigenous People (2007), article 38.

⁷⁸ Louise Alliston and Debbie Cossar, *The participation and engagement of Māori in decision-making processes and other government initiatives: A literature review prepared for the Electoral Commission* (Research New Zealand, 2006), at 15.

⁷⁹ *Wellington International Airport v Air New Zealand* [1993] 1 NZLR 671 at 675.

Failure to Consult or Adequately Consult with the Claimants

109. The Crown has failed to consult the Claimants on decisions that would have a significant impact on them.
110. The Claimants are treaty partners with the Crown and not merely one group among many health and disability system stakeholders.
111. The Crown has failed to recognise this special status and engage with the Claimants accordingly in its provision of community consultation opportunities.
112. Where the Crown does consult with the Claimants, its consultation practices are flawed and inappropriate for engagement with them as Māori.⁸⁰
113. Community consultation processes with the Claimants on health initiatives and service changes are inadequate considering the flaws in the Crown consultation model which include but are not limited to the following:⁸¹
 - a. Poor timing of and timeframes for consultation processes;
 - b. The inadequate level of information provided to enable informed participation;
 - c. The cost of participation in consultation processes;
 - d. The rigid structure provided to give feedback;
 - e. Engagement with the wrong people; and
 - f. Asking the wrong questions of Māori participants.
114. The lack of knowledge of te reo Māori, basic tikanga and te Tiriti among disability sector leaders and staff creates a barrier to establishing strong

⁸⁰ Heather Came, *Institutional Racism and the Dynamics of Privilege in Public Health* (Thesis, University of Waikato, 2012), at 274.

⁸¹ Heather Came, *Institutional Racism and the Dynamics of Privilege in Public Health* (Thesis, University of Waikato, 2012), at 277.

relationships and engaging in effective community consultation with the Claimants.⁸²

115. Due to cultural incompetence among Crown officials, consultation processes, when they occur, are often flawed in what is asked, how it is asked and who is asked.⁸³
116. The Crown has failed its duty to ensure that the Claimants who participate in community consultation opportunities are adequately informed with enough information to be able to make intelligent and useful responses.⁸⁴
117. The Crown has failed to consider and provide for the following barriers to engagement and consultation that the Claimants as Māori face, particularly small and medium-sized groups or communities, which include but are not limited to:⁸⁵
 - a. A lack of time and resources for participation in community consultation processes;
 - b. The internal decision-making capability of tangata whenua to respond quickly to all consultation requests;
 - c. Basic costs to attend consultation (petrol, bus fares, wages, stationary, computers, internet access, reference libraries, administrative services, expert advice);
 - d. Lack of staff with relevant expertise;
 - e. A reliance on volunteers; and

⁸² Louise Alliston and Debbie Cossar, *The participation and engagement of Maori in decision-making processes and other government initiatives: A literature review prepared for the Electoral Commission* (Research New Zealand, 2006), at 13.

⁸³ Heather Came, *Institutional Racism and the Dynamics of Privilege in Public Health* (Thesis, University of Waikato, 2012), at 274.

⁸⁴ Ministry of Health, *Consultation Guidelines for the Ministry of Health* dated 2002, at 2.

⁸⁵ Louise Alliston and Debbie Cossar, *The participation and engagement of Maori in decision-making processes and other government initiatives: A literature review prepared for the Electoral Commission* (Research New Zealand, 2006), at 11.

- f. Lack of information.

FIFTH CAUSE OF ACTION: THE CROWN FAILURE TO PROVIDE ADEQUATELY FOR KAUPAPA MĀORI IN THE PROVISION OF DISABILITY SUPPORT SERVICES

Allegation

118. The Crown, in breach of te Tiriti principles of active protection, good faith and partnership, has failed to implement culturally appropriate disability support services resulting in poor health outcomes for the Claimants.

Particulars

119. Kaupapa Māori is a theoretical Māori framework that is grounded within te reo Māori and tikanga Māori. It is informed by its cultural underpinnings and is controlled and defined by Māori.⁸⁶
120. In order to understand, explain and respond to Māori disability issues, there must be a theoretical framework that is built from Papatūānuku (the land), which provides ways of understanding the cultural, political and historical context of New Zealand.⁸⁷
121. Until the late 1990s, the Crown adopted a ‘mainstreaming’ approach, whereby Māori health issues were viewed as best addressed in an environment where there was a focus on high-quality outcomes for all New Zealanders, rather than in terms of ethnicity.⁸⁸
122. The introduction of Whānau Ora was an attempt to deliver healthcare services through a culturally appropriate frame. However, the Crown has failed to sufficiently apply this framework to disability services.

⁸⁶ Leonie Pihama, *Kaupapa Māori Theory: Transforming Theory in Aotearoa* (He Pukenga Korero: A Journal of Māori Studies, Vol 9, No 2, 2010), at 5.

⁸⁷ Leonie Pihama, *Kaupapa Māori Theory: Transforming Theory in Aotearoa* (He Pukenga Korero: A Journal of Māori Studies, Vol 9, No 2, 2010), at 5.

⁸⁸ Annabel Ahuriri-Driscoll, *Health Policy, health inequalities and Māori* (University of Canterbury, 2016), at 7.

123. The outcomes sought in the implementation of Whānau Ora are for whānau to be:⁸⁹
- a. Self-managing and empowered leaders;
 - b. Leading healthy lifestyles;
 - c. Participating fully in society;
 - d. Confidently participating in te ao Māori (the Māori world);
 - e. Economically secure and successfully involved in wealth creation; and
 - f. Cohesive, resilient and nurturing.

Māori Owned and Kaupapa Māori Services

124. There are approximately 33 Māori providers of disability services in Aoteroa (“Māori providers”).⁹⁰
125. Maori providers make up approximately 3.4% of the 980 providers currently operating.⁹¹
126. Māori providers received 3.9% of the funding available to DDS services in 2017/2018.⁹²
127. Services that Maori providers deliver include ‘home and community support’ and ‘community residential support’, as well as whānau support, information and advisory services and needs assessments.⁹³
128. The importance of these services to disabled Māori is critical.
129. Receiving care and services within a culturally appropriate context can improve outcomes for disabled Māori.⁹⁴

⁸⁹ Hon Tariana Turia, *Whānau Ora: The theory and the practice* (Best Practice Journal, Issue 37, 2017), at 12.

⁹⁰ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 158.

⁹¹ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 158.

⁹² T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 158.

⁹³ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 161 – 164.

⁹⁴ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 164.

130. Research shows that many Māori prefer to have services provided by Māori providers, citing the institutional racism and prejudice they face when accessing mainstream services.⁹⁵
131. Yet options for Māori wishing to be serviced by Māori providers remain few.⁹⁶
132. Numerous DHB areas do not have access to Māori disability providers including Taranaki, Mid-Central, Hutt Valley, Wairarapa, Nelson-Marlborough and South Canterbury.⁹⁷
133. Therefore, not all disabled Māori have access to Māori-provided disability services.

Failure to Provide Culturally Appropriate Care

134. The behaviour and attitudes of mainstream healthcare providers contributes to the following disparities in Māori health:⁹⁸
 - a. Māori receive fewer referrals, fewer diagnostic tests and less effective treatment plans than non-Māori patients;⁹⁹
 - b. Māori are less likely to be offered treatment;¹⁰⁰ and
 - c. Māori are also prescribed fewer secondary services such as physiotherapy and rehabilitation.¹⁰¹

⁹⁵ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 166 – 168.

⁹⁶ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 165.

⁹⁷ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 159.

⁹⁸ Kira Bacal, Peter Jansen, Kathleena Smith, *Developing Cultural Competency in Accordance with the Health Practitioners Competence Assurance Act* (The New Zealand Family Physician, November 2006), at 307.

⁹⁹ Kira Bacal, Peter Jansen, Kathleena Smith, *Developing Cultural Competency in Accordance with the Health Practitioners Competence Assurance Act* (The New Zealand Family Physician, November 2006), at 307.

¹⁰⁰ Kira Bacal, Peter Jansen, Kathleena Smith, *Developing Cultural Competency in Accordance with the Health Practitioners Competence Assurance Act* (The New Zealand Family Physician, November 2006), at 307.

¹⁰¹ Kira Bacal, Peter Jansen, Kathleena Smith, *Developing Cultural Competency in Accordance with the Health Practitioners Competence Assurance Act* (The New Zealand Family Physician, November 2006), at 307.

135. Matching the demographic of the workforce to the demographic of the population will enable access to culturally appropriate disability services and is a critical step in addressing health inequities.¹⁰²
136. Consultation with Māori groups has illustrated that the most significant contribution the Crown can make to promote better access to disability support and services is by consulting with and handing resources over to Māori to control and manage.¹⁰³
137. Therefore, the provision of disability services to the Claimants will be most effective in attaining positive health outcomes where there is:
- a. Policy designed for Māori, by Māori;¹⁰⁴
 - b. Strong Māori participation as a consumer and provider;
 - c. Holistic approaches to measuring health;¹⁰⁵ and
 - d. A shift from clinical outcomes to outcome measures that reflect Māori values and views on health.¹⁰⁶

Untailored Provision of Services for Disabled Peoples

138. DHBs are largely responsible for the delivery of support and health services for disabled peoples.¹⁰⁷ However, as the major supplier of these services, DHBs have disjointed approaches and lack both Māori and disabled representation.

¹⁰² Committee on the Elimination of All Forms of Racial Discrimination, *Shadow Report: Aotearoa New Zealand* (United Nations, 2017), at 9.

¹⁰³ Ruth Nepia, *Te Ara Ahu Whakamua: Proceedings of the Māori Health Decade Hui March 1994* (Te Puni Kōkiri/Ministry of Maori Development, 1994), at 2.

¹⁰⁴ Annabel Ahuriri-Driscoll, *Health Policy, health inequalities and Māori* (University of Canterbury, 2016), at 2.

¹⁰⁵ Committee on the Elimination of All Forms of Racial Discrimination, *Shadow Report: Aotearoa New Zealand* (United Nations, 2017), at 9.

¹⁰⁶ Committee on the Elimination of All Forms of Racial Discrimination, *Shadow Report: Aotearoa New Zealand* (United Nations, 2017), at 9.

¹⁰⁷ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 136.

139. Only two members of each DHB board are required to be Māori, and there are no explicit requirements that any member must be disabled.¹⁰⁸
140. The decisions regarding the provision of services to disabled Māori are often uninformed by Māori and/or by Maori with lived experiences of disabilities.
141. The services which are provided by the Ministry of Health can overlook the particular needs of disabled Māori given that a “one size fits all” approach is employed.¹⁰⁹
142. Some policies and practices for addressing the particular needs of disabled Māori, such as *Whāia Te Ao Mārama – The Māori Disability Action Plan 2018-2022*, are informed by Māori with lived experiences of disabilities.¹¹⁰ However, there is no legislative requirement for the implementation of policy and practice such as this and so it is not utilised or it is under-utilised.
143. *Whāia Te Ao Mārama – The Māori Disability Action Plan 2018-2022* is not considered to be one of the “key priority areas in the overall work programme for the Disability Directorate.”¹¹¹

Māori Workforce Crisis

144. An integral part of effective disability support for the Claimants is to address the critical shortage and under-representation of Māori health workers within the disability support sector.¹¹²
145. The lack of Crown initiatives to train, recruit and retain Māori disability support and healthcare workers has hindered the provision of culturally appropriate disability services to the Claimants.¹¹³

¹⁰⁸ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 137.

¹⁰⁹ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 138.

¹¹⁰ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 149.

¹¹¹ T King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, #B22, at 149.

¹¹² Elana Curtis and Mary-Jane Reid, *Indigenous Health Workforce Development: challenges and successes of the Vision 20:20 programme* (ANZ Journal of Surgery, Vol 83, 2012), at 49.

¹¹³ Lynne Russell (Pere), Kirsten Smiler and Hilary Stace, *Improving Māori Health and Reducing Inequalities Between Māori and Non-Māori: Has The Primary Health Care Strategy Worked for Māori? An Evaluation of the Period 2003-2010* (September 2013), at 52.

146. Of all New Zealanders, Māori comprise 15 percent of the population. Of this small group, only 2.6 percent are doctors, less than 1.5 percent are pharmacists, 2.1 percent are dentists and 7 percent are nurses.¹¹⁴
147. Evidence suggests that a lack of cultural co-ordination between patients and healthcare workers can reduce patient satisfaction, access and adherence to treatment plans.¹¹⁵
148. Māori health providers cannot compete with mainstream health and disability providers in terms of pay and opportunity, which has in turn led to an under-representation of Māori in the health and disability workforce and a reduction in the availability of Maori-led health and disability services.

Educational disparities

149. The most significant barrier to Māori participating in the health and disability workforce arises from the educational disparities in secondary and tertiary education for Māori compared to non-Māori.¹¹⁶
150. In 2016, Māori students had the lowest proportion of school leavers who achieved NCEA Level 3 or higher. Only 33.8 percent of Māori achieved NCEA Level 3, compared to Asian (75.5 percent), European/Pakeha (57.6 percent) and Pasifika (43.4 percent) students;¹¹⁷
151. Government-funded programmes that aim to recruit an increased amount of secondary school students into the health and disability workforce should be used as a mechanism to attract Māori students.¹¹⁸

¹¹⁴ Elana Curtis and Mary-Jane Reid, *Indigenous Health Workforce Development: challenges and successes of the Vision 20:20 programme* (ANZ Journal of Surgery, Vol 83, 2012), at 49.

¹¹⁵ Elana Curtis, Erena Wikaire, Kanewa Stokes and Papaarangi Reid, *Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes* (Tōmaiōra Seminar, 2012).

¹¹⁶ Elana Curtis and Mary-Jane Reid, *Indigenous Health Workforce Development: challenges and successes of the Vision 20:20 programme* (ANZ Journal of Surgery, Vol 83, 2012), at 49.

¹¹⁷ Education Counts, *School leavers with NCEA level 3 or above* (Ministry of Education, 2017).

¹¹⁸ Elana Curtis, Erena Wikaire, Kanewa Stokes and Papaarangi Reid, *Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes* (Tōmaiōra Seminar, 2012), at 2.

152. Early intervention is required to enable Māori students to participate within the health workforce. The Crown has failed to adequately implement initiatives that:
- a. Encourage Māori students to choose appropriate prerequisite subjects at secondary school;¹¹⁹
 - b. Provide support to ensure Māori students have the necessary building blocks to progress into completing tertiary health and disability programmes;¹²⁰
 - c. Actively include Māori parents, whānau and the wider community to influence career options;¹²¹
 - d. Provide bridging and foundation courses to aid the acquisition of study skills required for tertiary study;¹²²
 - e. Continued culturally appropriate support throughout tertiary study; and
 - f. Recruitment programmes that imbibe te ao Māori and include aspects of tikanga and kaupapa Māori.¹²³
153. The Crown's strategy for the recruitment and retention of a Māori health and disability workforce is inadequate.

¹¹⁹ Elana Curtis, Erena Wikaire, Kanewa Stokes and Papaarangi Reid, *Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes* (Tōmaiora Seminar, 2012), at 10.

¹²⁰ Elana Curtis, Erena Wikaire, Kanewa Stokes and Papaarangi Reid, *Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes* (Tōmaiora Seminar, 2012), at 10.

¹²¹ Elana Curtis, Erena Wikaire, Kanewa Stokes and Papaarangi Reid, *Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes* (Tōmaiora Seminar, 2012), at 10.

¹²² Elana Curtis, Erena Wikaire, Kanewa Stokes and Papaarangi Reid, *Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes* (Tōmaiora Seminar, 2012), at 11.

¹²³ Elana Curtis, Erena Wikaire, Kanewa Stokes and Papaarangi Reid, *Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes* (Tōmaiora Seminar, 2012), at 13.

154. The inequities suffered by the Claimants in respect of their disability needs will not be reduced until education outcomes for Māori improve.

SIXTH CAUSE OF ACTION: INSTITUTIONAL RACISM IN THE DISABILITY SUPPORT SYSTEM

Allegation

155. The Crown, in breach of te Tiriti principles of active protection, good faith and partnership, has failed to protect the Claimants from poor health outcomes as a result of inequity within the disability support service system, including chronic disparities between Māori and non-Māori health, perpetuated through unconscious bias, sites of interpersonal racism and institutional racism in the health and disability support system.

Particulars

Institutional Racism

156. Racism impacts on the Claimants' disability support through multiple pathways,¹²⁴ such as interpersonal racism, institutional racism and unconscious bias.

157. Institutional racism, also called structural racism, is defined as:¹²⁵

An entrenched pattern of differential access to material resources and state power determined by ethnicity and culture, which advantages one population while disadvantaging another.

158. Māori with lived experience of disability have been impacted even further due to the intersection of Māori experience of disability with colonisation, coloniality and racism.¹²⁶

¹²⁴ New Zealand College of Public Health Medicine, *NZCPHM Māori Health Policy Statement* dated November 2015, at 3.

¹²⁵ Heather Came, Timothy McCreanor, *Pathways to Transform Institutional (and Everyday) Racism in New Zealand* (Journal of Social Anthropology and Cultural Studies, Vol 12, No 2, 2015), at 2.

¹²⁶ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 353.

159. The impacts experienced by Māori with lived experience of disability are compounded by culturally unsafe models of health imposed upon Māori, in addition to Māori experiences of institutional racism, and explicit and implicit bias within health and disability services.¹²⁷
160. As a population group, the persistent, significant, and pervasive inequities impacting on Māori with lived experience of disability, demonstrate that they have experienced, and continue to experience, the disproportionate impact of the Crown's actions and inactions.¹²⁸
161. The legacy of the Crown's historic approaches to Māori health and well-being since the 1840s includes no acknowledgement of the right of Māori to be self-determining. It has restricted the opportunity for Māori to develop, establish and sustain indigenous approaches to disability.¹²⁹
162. Crown organisations often use high level strategic statements to indicate a commitment to Māori health and equity, but these statements are usually silent on Māori with lived experience of disability.¹³⁰
163. Dr Heather Came identified five modifiable sites of institutional racism within public health policy making;¹³¹
- a. Majoritarian decision-making practices which marginalise Māori views;
 - b. Failure to draw on Māori evidence and over-reliance on best practice evidence from the global north;
 - c. Deficiencies in cultural and political competencies of policy analysts;
 - d. Flawed consultation processes;

¹²⁷ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 353.

¹²⁸ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 353.

¹²⁹ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 353.

¹³⁰ Dr Paula Therese King, *Māori with Lived Experience of Disability Part 1* dated 24 June 2019, Wai 2575, B022, at 354.

¹³¹ Committee on the Elimination of All Forms of Racial Discrimination, *Shadow Report: Aotearoa New Zealand* (United Nations, 2017), at 6-9.

e. Organisational sign-off processes that dilute Māori content.

164. Collectively, these findings indicate the systemic failure of quality assurance systems, existing anti-racism initiatives, and health sector leadership to detect and eliminate racism.¹³²

Effects of structural racism

165. The maladministration of Māori education by the Crown has led to under-representation of Māori in the health and disability workforce.¹³³

166. Māori health and disability professionals represent 7 percent of the health workforce, despite Māori being 15 percent of the general population.

167. Institutional racism is manifested in the biased treatment of Māori organisations by state agencies when contracting with Māori organisations for service delivery.¹³⁴

168. In July 2009 the Health Select Committee recommended that the Government establish a working group 'consisting of representatives from the Māori and iwi service providers, the DHBs, nurses' organisations, and the Ministry of Health'¹³⁵ to address the pay inequities.

169. In August 2009 the Crown indicated that they did not support the Health Select Committee's unanimous recommendation, and no further progress was made.¹³⁶

170. Māori and iwi health workers earn up to 25 percent less than their colleagues in hospital settings.¹³⁷

¹³² Committee on the Elimination of All Forms of Racial Discrimination, *Shadow Report: Aotearoa New Zealand* (United Nations, 2017), at 7.

¹³³ Papaarangi Reid and Bridget Robson, *Understanding health inequities* (University of Otago, 2007).

¹³⁴ Charlotte Moore, *A Whakapapa of Whanau Ora: A new way of delivering social services in Aotearoa New Zealand* (University of Auckland, 2014), at 7.

¹³⁵ Health Select Committee, *Petition 2005/177 of Ngaitia Nagel and 11,370 others* dated 11 May 2009, at 2.

¹³⁶ Human Rights Commission, *A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services* dated July 2012, at 21.

¹³⁷ Human Rights Commission, *A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services* dated July 2012, at 21.

171. This funding inequity between Māori and non-Māori health and disability workers is a barrier to the recruitment and retention of Māori health and disability workers, and the Claimants submit, institutional racism.

Effects of interpersonal racism on physical health

172. Interpersonal racism can be defined as racism which occurs at a micro level in specific interactions between individuals.
173. Discrimination perpetuated by interpersonal racism impacts negatively on the health of indigenous peoples.¹³⁸
174. Healthcare professionals have exhibited interpersonal racism towards Māori disability consumers, including the Claimants.
175. Experiencing racism increases the odds of delayed care or unmet need, also increasing the likelihood of the Claimants not proceeding with the recommended advice.¹³⁹

Unconscious Bias in the Health System

176. Unconscious bias refers to a social stereotype about certain groups of people that individuals form outside their own conscious awareness. These biases stem from an innate human tendency to organise social worlds by categorising.
177. Studies show Māori are highly vulnerable to unconscious bias in New Zealand, due to stereotypes held against Māori.¹⁴⁰

¹³⁸ Donna Cormack, James Stanley, Ricci Harris, *Multiple forms of discrimination and relationships with health and wellbeing: findings from national cross-sectional surveys in Aotearoa/New Zealand* (International Journal for Equity in Health, Vol 17, 2018).

¹³⁹ Jehonathan Ben, Donna Cormack, Ricci Harris, Yin Paradies, *Racism and health service utilisation: A systematic review and meta-analysis* (PloS ONE Vol 12, 2017), at 14.

¹⁴⁰ Anton Blank, Dr Carla Houkamau and Dr Hautahi Kingi, *Unconscious Bias and Education: A comparative study of Māori and African American students* (Oranui, 2016), at 31.

178. International and New Zealand research has detailed pervasive evidence of unconscious bias in institutions including the health and disability system.¹⁴¹
179. The United Nations Committee on Economic, Social and Cultural Rights is 'concerned about the entrenched unconscious bias towards Māori in education, health, justice and social services, negatively affecting their enjoyment of economic, social and cultural rights'.¹⁴²
180. Unconscious bias against Māori among health workers and professionals creates negative health outcomes for the Claimants.
181. Māori are almost three times as likely as non-Māori to have experienced unfair treatment based on ethnicity.¹⁴³
182. Many Māori consumers of health and disability services feel they are treated with disrespect because they are Māori, and believe they are treated differently from how they see Pakeha patients getting treated.¹⁴⁴
183. The structural racism inherent in the health system, which is perpetuated by Crown inaction, has enabled the unconscious bias of health and disability professionals and workers to negatively impact the provision of disability support services to the Claimants.
184. The Crown has failed to ensure that adequate training in unconscious bias is provided to health and disability workers and professionals in order to reduce the impact of such bias on the Claimants.

¹⁴¹ The University of Auckland, *Bias in employment and education*, accessed at <<https://www.auckland.ac.nz/en/about-us/about-the-university/equity-at-the-university/safe-inclusive-equitable-university/unconscious-bias/bias-in-employment-and-education.html>>.

¹⁴² Committee on Economic, Social and Cultural Rights, *Concluding observations on the fourth periodic report of New Zealand* (United Nations, 2018), at 3.

¹⁴³ New Zealand Health Survey 2011/2012, cited in Anton Blank, Dr Carla Houkamau and Dr Hautahi Kingi, *Unconscious Bias and Education: A comparative study of Māori and African American students* (Oranui, 2016), at 2.

¹⁴⁴ Anton Blank, Dr Carla Houkamau and Dr Hautahi Kingi, *Unconscious Bias and Education: A comparative study of Māori and African American students* (Oranui, 2016), at 10.

SEVENTH CAUSE OF ACTION: THE CROWN FAILURE TO PROVIDE ADEQUATELY INTEGRATED HEALTH AND DISABILITY SUPPORT SERVICES TO MĀORI

Allegation

28. In breach of the te Tiriti principles of partnership, active protection and good faith, the Crown has failed to implement effectively integrated healthcare and disability support services, which has exacerbated the Claimants' poor health outcomes.

Particulars

Failure to Establish Effective Integrated Care

29. Historically, the health system has provided highly fragmented and poorly co-ordinated services to users.¹⁴⁵
30. The Crown has failed to establish sufficiently integrated healthcare and disability support services in order to provide better health outcomes for the Claimants.
31. 'Integrated care' may refer to the linking together of key planning, funding, and service delivery activities to support co-ordination, and a single budget for integrated service delivery organisations which would provide a wide range of services to their enrolled populations.¹⁴⁶
32. New Zealand's health system is highly fragmented, and services used by the Claimants are poorly co-ordinated.¹⁴⁷
33. Fragmentation arises because the Claimants as healthcare consumers receive care from a wide range of professionals who work in a large number of provider organisations.

¹⁴⁵ J Cumming, *Integrated Care in New Zealand* (Integrated Journal of Integrated Care, Vol 11, 2011), at 1.

¹⁴⁶ J Cumming, *Integrated Care in New Zealand* (Integrated Journal of Integrated Care, Vol 11, 2011), at 2.

¹⁴⁷ J Cumming, *Integrated Care in New Zealand* (Integrated Journal of Integrated Care, Vol 11, 2011), at 1.

34. A lack of information sharing and liaison between health and disability professionals across provider organisations results in poorly co-ordinated care for the Claimants.
35. The Crown has allowed major separations and fragmentation in planning, funding and provision of healthcare services to exist since the mid-to-late 1800s.
36. The dis-integration of planning and funding also occurred under the NZPHD Act, as some healthcare services became the responsibility of the Ministry instead of the DHBs, including disability support services for those aged 65 and under.
37. The following examples of fragmentation in services prevent the Claimants from accessing effective and co-ordinated care from providers:
 - a. General practitioners act as 'gatekeepers' to a range of referred services, such as physiotherapists;
 - b. Disability services, including those with physical, age-related, intellectual and psychiatric disabilities, are also fragmented, with many services delivered by community-led, not-for-profit organisations.
38. Providing adequately integrated care includes ensuring the Claimants have good access to health and disability providers, who should co-ordinate the care that they provide.
39. A lack of information sharing and liaison between providers results in poorly co-ordinated care, with the following results that create poor health outcomes for Māori, including the Claimants:
 - a. Patients slip through gaps in the system;
 - b. Patients are seen by multiple providers for the same condition;
 - c. There is a risk of harm occurring from the use of incompatible medications being prescribed by different providers; and
 - d. Patients may receive different health advice from different health providers.

40. The Crown has acknowledged integrated care as an important goal since as early as the 1960s.¹⁴⁸ However to this day it has failed to provide adequately integrated services, to the detriment of the Claimants' health outcomes.

District Health Board Initiatives

41. Efforts to improve service delivery and achieve integrated care have been made at a local level, such as projects implemented by Counties Manukau District Health Board ("CMDHB"). Such efforts are ad hoc across DHBs and community providers and are driven by visionary local leaders, rather than the result of Crown intention and action.

42. CMDHB has developed projects in response to concerns about poor co-ordination between primary and secondary services. Examples of these initiatives include the following:¹⁴⁹

- a. Improving links between patients and their primary care services;
- b. Increasing the role of primary care providers in care delivery;
- c. Improving information systems to reduce duplication and prevent gaps in service delivery;
- d. Improving discharge planning;
- e. Increasing the use of treatment and referral guidelines; and
- f. Developing care co-ordination tools to improve care.

185. The Crown is aware of these projects and their potential for improving health outcomes of Māori, however despite this knowledge it has not taken adequate steps to implement such initiatives across the health system at large.

¹⁴⁸ John Bired Lovell-Smith, *The New Zealand doctor and the welfare state* (Blackwood and Janet Paul, Auckland, 1966); William Ball Sutch, *The quest for security in New Zealand: 1840-1966* (Oxford University Press, Wellington, 1966).

¹⁴⁹ J Cumming, *Integrated Care in New Zealand* (Integrated Journal of Integrated Care, Vol 11, 2011), at 5.

Lack of Support for Whānau Ora

43. Whānau Ora is a model of providing integrated primary care and wraparound services that is targeted specifically at Māori whānau.
44. Crown funding for Whānau Ora for 2018-2019 is \$80 million.
45. The funding for Whānau Ora is less than one percent of the annual Vote Health budget.
46. Crown funding for Whānau Ora is inadequate in relation to the objectives of that funding.
47. There is a lack of accountability in the Whānau Ora model which makes any progress in primary health outcomes for the Claimants hard to measure because of the broad spectrum of Whānau Ora Commissioning Agencies and their contracting providers.
48. The lack of government support for Whānau Ora and other initiatives that are targeted to improving the integration of health and disability services for Māori is a breach of the Crown's duty of active protection, in that it sustains and exacerbates the poor health outcomes suffered by the Claimants.

Application to Claimants

186. The named Claimant suffered a physical impairment that limited his ability to engage in full time work.
187. The named Claimant's impairment did not fall within the Ministry of Health definition of 'disability' and the named Claimant was unable to receive MOH funded disability support services as a result.
188. The named Claimant was able to obtain some limited ACC support which included some physio and elective surgeries. The named Claimant received his sickness benefit payments from WINZ.
189. However, his partners income stopped the named Claimant from receiving the much-needed financial support.

190. Every time the named Claimant required pain medication he had to pay to see his general practitioner.
191. The fragmentation of services meant that the various organisations did not consider the named Claimant's experience of his disability in totality. Each person looked only at what they could or could not do within their own policy guidelines. There were no holistic wraparound services considered or provided.
192. It was up to the named Claimant to navigate a very complex system to receive required support.
193. The named Claimant's knee injury worsened as a result and he can now no longer work.

EIGHTH CAUSE OF ACTION: THE CROWN FAILURE TO ADEQUATELY COLLECT AND USE DISABILITY-RELATED DATA

Allegation

194. In breach of the te Tiriti principles of partnership, active protection and good faith, the Crown has failed to adequately collect, use and monitor high-quality data in order to provide relevant and adequate disability support services.

Insufficient Information held by the Crown for Māori with lived experience of disability

195. The Crown does not hold comprehensive information for Māori with lived experience of disability.
196. Data collected by the Crown for the purpose of identifying, measuring and addressing inequities in service and outcomes for Māori with lived experience of disability is not effective.¹⁵⁰
197. Crown data collection issues can be summarised as follows:

¹⁵⁰ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 282.

- a. The Crown uses inconsistent definitions of ethnicity in disability data collection;¹⁵¹
- b. The Crown uses varied definitions of disability when collecting data;¹⁵²
- c. The identification of disability is currently not possible in the New Zealand Health Survey meaning it is difficult to identify which Māori have a disability within the Ministry's datasets. ¹⁵³
- d. The Crown uses variable data collection methods in disability data collection meaning the incidence of disability cannot be tracked over time;¹⁵⁴
- e. The Crown fails to incorporate culturally specific measures of impairment, disability and functions in data collection;¹⁵⁵
- f. The Crown fails to collect adequate data relating to Māori understandings of disability; ¹⁵⁶
- g. The Crown fails to collect adequate data relating to Māori Disability support service preferences;¹⁵⁷
- h. Disability is not able to be identified in the majority of the national health surveys meaning the health status of the total Māori disability population cannot be determined. ¹⁵⁸
- i. The Ministry of Health disability support data is limited in its usefulness to the level of examining trends in service utilisation. ¹⁵⁹

¹⁵¹ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 208-211.

¹⁵² Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 208-211.

¹⁵³ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 211.

¹⁵⁴ Wai 2575, #B24, The Crown Maori Disability Statistical Report, at 4.

¹⁵⁵ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 204.

¹⁵⁶ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 205.

¹⁵⁷ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 205.

¹⁵⁸ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 282.

¹⁵⁹ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 283.

- j. Disability questions used in the New Zealand Health Survey for adults are informed by a Western model and have not been informed by indigenous conceptualisations of disability.¹⁶⁰
198. Data quality issues undermine disability support planning, purchasing and the development of policies aimed at Māori.¹⁶¹
199. Information held by the Ministry of Health relating to the lived experience of disability data is used to inform policy decisions.
200. Therefore, Crown policies aimed at addressing the health needs of disabled Māori are formed based on incomplete data.

PREJUDICE

201. In relation to the provision of disability-related services, the Crown has failed to:
- a. properly collect and utilise Maori disability-related data;
 - b. provide adequate rural disability support services;
 - c. provide adequate opportunity for Maori community consultation on disability support services;
 - d. adequately provide for kaupapa Maori in the provision of disability support services;
 - e. address and prevent the adverse effects of institutional racism in the disability support system; and
 - f. provide adequate integrated healthcare services to Māori,
202. As a result, the Claimants have suffered the following prejudice:

¹⁶⁰ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 282.

¹⁶¹ Wai 2575, #B22 Maori with lived experience of Disability Part I, Dr Paula Therese King, at 204.

- a. Inadequate disability care and support provision;
- b. Lack of adequate Crown agency support and services;
- c. Inadequate provision of income support by the Crown;
- d. Overly restrictive qualification criteria imposed for income support to the detriment of the Claimant;
- e. A worsening health status due to inadequate disability support;
- f. Economic hardship as a result of inadequate income support from the Crown;
- g. Limited financial support to whānau carers of Māori with lived experience of disability;
- h. Institutional barriers to accessing health and disability services;
- i. Economic barriers to accessing health and disability services;
- j. Severely inadequate rural disability care and support provision;
- k. Delays and barriers to accessing rural disability services;
- l. Insufficient consultation with health officials about disability support-related issues;
- m. Marginalisation in relation to the development of disability support legislation, strategy and policies;
- n. Denigration of kaupapa Māori practices and knowledge in the disability support system;
- o. Limited options for Māori with lived experience of disability to access culturally appropriate care;

- p. Low Māori representation in the health and disability workforce;
 - q. Insufficient continuing medical education programmes for the Māori health and disability workforce.
 - r. Poor data coverage for Māori with lived experience of disability;
 - s. Poor quality data for Māori with lived experience of disability; and
 - t. Diminution of mana.
203. Adult Māori experience greater barriers to accessing health and disability support than the total population, which is exemplified by the following statistics from 2016/2017:¹⁶²
- a. 37.5 percent of Māori identified an unmet health need compared with 28.1 percent of the total population;
 - b. 21.4 percent of Māori were unable to get an appointment within the next 24 hours compared with 18.4 percent of the total population;
 - c. 22.2 percent of Māori did not visit a GP due to cost compared with 14.3 percent of the total population;
 - d. 7.5 percent of Māori did not visit a GP due to lack of transport compared with 3.2 percent of the total population;
 - e. 11.6 percent of Māori did not visit an after-hours medical centre due to the cost compared to 6.6 percent of the total population;
 - f. 3.3 percent of Māori did not visit an after-hours medical centre due to a lack of transport compared with 1.3 percent of the total population; and

¹⁶² Ministry of Health, *Annual Update of Key Results 2016/17: New Zealand Health Survey* dated 14 December 2017, accessed at <<https://minhealthnz.shinyapps.io/#!/home>>.

- g. 13.8 percent of Māori did not fill a prescription due to cost compared with 7.0 percent of the total population.

RELIEF

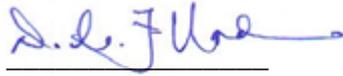
204. The relief sought is as follows:

- a. A sincere and public apology from the Crown to the Claimants for:
 - i. the prejudice they have suffered and continue to suffer;
and
 - ii. the disparity in health and disability support outcomes borne today as a result of the Crown's failure to provide adequate health and disability services to Māori; and
- b. Findings that the causes of action are well-founded;
- c. Findings that the Crown breached its duties of partnership, active protection, equality, and good faith that it owed to the Claimants in its inadequate funding and provision of health and disability services;
- d. A recommendation that the Crown provide adequate funding to design an appropriate system of health and disability care provision;
- e. A recommendation that the Crown improve access to financial support for disabled Māori;
- j. A recommendation that the Crown makes it mandatory for DHBs to regularly collect and provide Māori health and disability statistics and data to the Ministry of Health and to Māori health organisations;
- k. A recommendation that the Crown standardise the collection of Māori health and disability statistics and evaluation data by all DHBs;

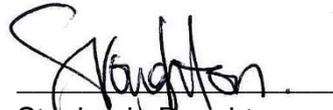
- l. A recommendation that the Crown ensure knowledge of tikanga, te reo and Māori health practices among all health and disability practitioners and administrators working in the health and disability system;
- m. A recommendation that the Crown provide for non-discriminatory monitoring of Māori health and disability services by government agencies;
- n. A recommendation that the Crown ensure pay equity for Māori health workers and Māori nurses across the New Zealand health system, including for Māori health and disability workers who work for Māori health providers;
- o. A recommendation that the Crown implement a Māori-only community consultation model that would enhance Māori participation in health consultation opportunities;
- p. A recommendation that the Crown make provision for well-equipped mobile health and disability services in rural areas;
- q. A recommendation that the Crown make provision for triennial government contacts with Maori health and disability service providers, instead of annual government contracts;
- r. A recommendation that the Crown exclude international commercial interests in the provision of health and disability services to Māori by way of the Comprehensive and Progressive Agreement for the Trans-Pacific Partnership; and

- s. Such other findings and recommendations that the Tribunal considers appropriate in the circumstances.

Dated at **Auckland** this **12th** day of **December 2019**



Darrell Naden
Counsel Acting



Stephanie Roughton
Counsel Acting



Natasha Hall
Counsel Acting

This Statement of Claim is filed by **DARRELL CY FREDERICK NADEN**, Solicitor for the Claimants, of the firm **Tamaki Legal Limited**. The address for service of the Claimants is at the office of Tamaki Legal Ltd, Barristers and Solicitors, Level 2, 15 Osterley Way, Manukau, Auckland. Documents for service on the Claimants may be left at that address for service or may be:

- (a) Posted to the Solicitor at PO Box 75-517, Manurewa, Auckland 2243; or
- (b) Emailed to the solicitors at darrell@tamakilegal.com.